MEDICUS™
INSURANCE COMPANY

MANUAL

SECTION I

GENERAL RULES

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS AND NON-PHYSICIAN HEALTH CARE PROVIDERS

I. APPLICATION OF MANUAL

This manual specifies rules, rates, premiums, classifications and territories for the purpose of providing professional liability coverage to the physicians, surgeons, their professional associations and employed health care providers.

II. APPLICATION OF GENERAL RULES

These rules apply to all sections of this manual. Any exceptions to these rules are contained in the respective section, with reference thereto.

All other rules, rates and rating plans filed on behalf of the Company and not in conflict with these pages shall continue to apply.

III. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter, but the policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year under a short term policy period.

IV. LOCATION OF PRACTICE

The rates as shown in this manual contemplate the exposure as being derived from professional practice or activities within a single rating territory. However, should an insured practice in more than one rating territory and/or state, the following rule shall apply. If 10% or less of an insured's practice is in a higher rated territory, we use the lower rated territory. If more than 10% of an insured's practice is in a higher rated territory, we use the higher rated territory.

V. PREMIUM COMPUTATION

A. Compute the premium at policy inception using the rules, rates and rating plans in effect at that time. At each renewal, compute the premium using the rules, rates and rating plans then in effect.

superseded

B. Premiums are calculated as specified for the respective coverage. Premium rounding will be done at each step of the computation process in accordance with the Whole Dollar Rule, as opposed to rounding the final premium.

VI. FACTORS OR MULTIPLIERS

Wherever applicable, factors or multipliers are to be applied consecutively and not added together.

VII. WHOLE DOLLAR RULE

In the event the application of any rating procedure applicable in accordance with this manual produces a result that is not a whole dollar, each rate and premium shall be adjusted as follows:

A. any amount involving $.50 or over shall be rounded up to the next highest whole dollar amount; and

B. any amount involving $.49 or less shall be rounded down to the next lowest whole dollar amount.

VIII. ADDITIONAL PREMIUM CHARGES

A. Prorate all changes requiring additional premium.

B. Apply the rates and rules that were in effect at the inception date of this policy period. After computing the additional premium, charge the amount applicable from the effective date of the change.

IX. RETURN PREMIUM FOR MID-TERM CHANGES

A. Compute return premium at the rates used to calculate the policy premium at the inception of this policy period.

B. Compute return premium pro rata when any coverage or exposure is deleted or an amount of insurance is reduced.

C. Retain the Policy Minimum Premium.

X. POLICY CANCELLATIONS

A. Compute return premium pro rata using the rules, rates and rating plans in effect at the inception of this policy period when:

1. A policy is canceled at the Company's request,

2. the insured no longer has a financial and an insurable interest in the property or operation that is the subject of the insurance; or

B. If cancellation is for any other reason than stated in A. above, compute the return premium on a standard short rate basis for the one-year period.

C. Retain the Policy Minimum Premium when the insured requests cancellation except when coverage is canceled as of the inception date.

XI. POLICY MINIMUM PREMIUM

1. The applicable minimum premium is determined by the type of health care provider shown on the appropriate Rate Pages.

2. Minimum Premiums will be combined for a policy that provides coverage for more than one type of health care provider.

XII. PREMIUM PAYMENT PLAN

The Company will offer the insured premium payment options, outlined on Page 28.

XIII. COVERAGE

Coverage is provided on a Claims-Made basis. Coverage under the policy shall be as described in the respective Insuring Agreements. The coverages will be rated under Standard Claims-Made Rates.

XIV. BASIC LIMITS OF LIABILITY

Basic Limits of Liability shall be those shown as applicable to the respective insureds.

XV. INCREASED LIMITS OF LIABILITY

Individual Limits of Liability will be modified by Increased Limits factors as applicable for the respective insureds and used to develop the applicable premium.

XVI. PRIOR ACTS COVERAGE

The policy shall be extended to provide prior acts coverage in accordance with the applicable retroactive date(s). The retroactive date can be advanced only at the request or with the written acknowledgment of the insured, subject to underwriting.

XVII. EXTENDED REPORTING PERIOD COVERAGE

The availability of Extended Reporting Period Coverage shall be governed by the terms and conditions of the policy and the following rules:

A. The retroactive date of coverage will determine the years of prior exposure for Extended Reporting Period Coverage.

B. The Limits of Liability may not exceed those afforded under the terminating policy, unless otherwise required by statute or regulation.

C. The premium for the Extended Reporting Period Coverage shall be determined by applying the Extended Reporting Period Coverage rating factors shown on Page 25.

D. Premium is fully earned and must be paid in full within 30 days of the expiration of the policy.

E. The Reporting Period is unlimited.

F. The Insured has 30 days after the policy is terminated to purchase the extended reporting period. The Extended Reporting Endorsement must be offered regardless of the reason for the termination.

XVIII. PREMIUM MODIFICATIONS

Schedule Rating

Physicians and Surgeons	+/- 25%
Healthcare Providers	+/- 25%

Scheduled Rating is not to be used in conjunction with Loss Rating.

- END OF SECTION I-

SECTION II

MANUAL PAGES FOR CORPORATIONS, PARTNERSHIPS AND ASSOCIATIONS

I. APPLICATION OF MANUAL

A. This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for the following Health Care Entities:

1. Professional Corporations, Partnerships and Associations

B. For the purpose of these rules, an entity consists of physicians, dentists and/or allied health care providers rendering patient care who:

1. Are comprised of 2 or more physicians;

2. Are organized as a legal entity;

3. Maintain common facilities (including multiple locations) and support personnel; and

4. Maintain medical/dental records of patients of the group as a historical record of patient care.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

A. Claims-Made Coverage

$1,000,000 Per Claim
$3,000,000 Aggregate

III. PREMIUM COMPUTATION

A. The premium for professional corporations, partnerships and associations shall be computed in the following manner:

1. The premium will be based on the number of years that the retroactive date (if claims made) of the partnership or professional corporation coverage precedes the policy inception date. At this maturity level, the premium will equal the product of the sum of the individual manual rates of the partners, shareholders and employed/contracted physicians/dentists/allied health care providers, insured by the Company, at the limits selected for the partnership or corporation times the partnership/corporation rating factor indicated under B1 on page 7.

2. Irrespective of the number of individuals, the maximum premium will be based on the five highest rated classifications, subject to any applicable modifications. However, for groups of 10 or more physicians, the Company may base the maximum premium on the sum of the shareholders' rated classifications.

3. Limits of coverage for the partnership or corporation may not exceed the lowest limits of coverage of any of the insured partners, shareholders or employed physicians/contracted physicians/dentists/allied health care providers, unless unique circumstances are identified and underwriting guidelines are met. These limits of coverage are shared, unless otherwise specified by endorsement.

B. A professional corporation or association may be made an additional insured on a solo provider's individual policy at no additional charge, subject to underwriting guidelines. This addition will not operate to provide additional limits of liability per health care occurrence or annual aggregate beyond the stated limits of the individual policy, unless otherwise required by statute.

IV. CLASSIFICATIONS

A. Corporations, Partnerships and Associations

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Not otherwise identified as a Miscellaneous Entity.

B. Miscellaneous Entities

1. As defined by state statutes and formed for the purpose of rendering specified medical/dental professional services.

2. Including the following types of entities:

   a. Urgent Care Center
   b. Surgi Center
   c. MRI Center
   d. Renal Dialysis Center
   e. Peritoneal Dialysis Center

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company,

uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated under D1 on this page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule-rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified on Page 27.

B. Manual Rates

1. Corporations, Partnerships & Associations Rating Factors

As referenced in III.A.1 on Page 5:

20% - Separate Corporate Limits

10% - Shared Corporate Limits

2. Miscellaneous Entities

Not eligible under this Filing.

C. Policy Writing Minimum Premium

The applicable minimum premium is based upon the policy issued to the physicians and surgeons. Only one minimum premium applies of $1250.

D. Premium Modifications

1. Schedule Rating—Partnerships & Corporations

Physician & Surgeons	+/- 25%
Health Care Providers	+/- 25%

Schedule Rating is not to be used in conjunction with Loss Rating.

2. Self-Insured Retention Credits - See Section III.V.B

- END OF SECTION II-

SECTION III

MANUAL PAGES FOR PROFESSIONAL LIABILITY COVERAGE FOR PHYSICIANS, SURGEONS, AND NON-PHYSICIAN HEALTHCARE PROVIDERS

I. APPLICATION OF MANUAL

This section provides rules, rates, premiums, classifications and territories for the purpose of providing Professional Liability for Physicians/Surgeons and employed or associated non-physician health care providers.

II. BASIC LIMITS OF LIABILITY

Basic Limits of Liability for Professional Liability Coverage under this program shall be as follows, unless otherwise modified by statute:

Claims-Made Coverage

$1,000,000 Per Claim

$3,000,000 Aggregate

III. PREMIUM COMPUTATION

The premium shall be computed by applying the rate per physician, surgeon or non-physician health care provider shown on Page 21, in accordance with each individual's medical classification and class plan designation.

IV. CLASSIFICATIONS

A. Physicians/Surgeons and Non Physician Health Care Providers

1. Each medical practitioner is assigned a Rate Class according to his/her specialty. When more than one classification is applicable, the highest rate classification shall apply.

2. The Rate Classes are found on Pages 14-19 of this Manual.

B. Part Time Physicians

1. A physician who is determined to be working 20 hours or less a week may be considered a part time practitioner and may be eligible for a reduction in the otherwise applicable rate for that specialty. The criteria and commensurate credit for a part time practitioner are identified in Section III of this Manual.

2. A Part Time Practitioner may include any practitioner in classes 1 through 3 only, except for Anesthesia and Emergency Medicine as identified in the class plan. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

3. The part time credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

C. Physicians in Training

1. Following graduation from medical school, a physician may elect to enter additional training periods. For rating purposes, they are defined as follows:

   a. First Year Resident (or Intern) - 1 year period immediately following graduation. During this period a physician may or may not be licensed, depending upon state requirements.

   b. Resident - various lengths of time depending upon medical specialty; 3 years average. Following first year residency, generally licensed M.D. Upon completion of residency program, physician becomes board eligible.

   c. Fellow - Follows completion of residency and is a higher level of training.

2. Coverage is available for activities directly related to a physician's training program. The coverage will not apply to any professional services rendered after the training is complete.

   a. Interns, Residents and Fellows are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for activities directly related to an accredited training program. The applicable credit is stated on Page 26.

3. The credit is not applied to the Extended Reporting Period Coverage.

4. No other credits are to apply concurrent with this rule.

D. Locum Tenens Physician

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.

2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.

3. Limits will be shared between the insured physician and the physician substituting for him/her and will be endorsed onto the policy.

E. New Physician

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:

   a. Residency;

   b. Fellowship program in their medical specialty

   c. Fulfillment of a military obligation in remuneration for medical school tuition;

   d. Medical school or specialty training program.

2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.

3. A reduced rate will be applied in accordance with the credits shown on Page 26. No other credits are to apply concurrent with this rule.

F. Physician Teaching Specialists

1. Coverage is available for faculty members of an accredited training program. The coverage will not apply to any professional services rendered in the insured's private practice.

   a. Faculty members are eligible for a reduction in the otherwise applicable physician rate for coverage valid only for teaching activities related to an accredited training program. Refer to L.5 on page 26 to determine the applicable credit.

2. Coverage is available for the private practice of a physician teaching specialist. The coverage will not apply to any aspect of the insured's teaching activities.

   a. The premium will be based upon the otherwise applicable physician rate and the average number of hours per week devoted to teaching activities.

   b. The hours reported to the Company for rating purposes are subject to audit, at the Company's discretion.

c. No other credits are to apply concurrent with this rule.

d. The applicable percentages are presented on Page 26.

G. Physician's Leave of Absence

1. A physician who becomes disabled from the practice of medicine, or is on leave of absence for a continuous period of 45 days or more, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.

2. This will apply retroactively to the first day of disability or leave of absence.

3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.

4. The credit to be applied to the applicable rate is presented on Page 26.

V. PREMIUM MODIFICATIONS

The following premium modifications are applicable to all filed programs.

A. Schedule Rating

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a risk may be modified in accordance with a maximum modification indicated on Page 27, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the specific considerations identified on Page 27.

B. Risk Management

1% credit will apply for each Company approved CME hour of risk management completed, up to a maximum of 5% credit per year, or attendance at a Company approved seminar.

C. Deductible Credits

Deductibles may apply either to indemnity only or indemnity and allocated loss adjustment expenses (ALAE). Any discount will apply only to the primary limit premium layer up to ($1M/$3M). Deductibles are subject to approval by the Company based on financial statements to be submitted by the insured and financial guarantees are required. The Company reserves the right to require acceptable securitization in the amount of the per claim and/or aggregate deductible amount from any insured covered by a policy to which a deductible is attached.

1. Individual Deductibles

Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

INDEMNITY ONLY DEDUCTIBLE PER CLAIM		INDEMNITY AND ALAE DEDUCTIBLE PER CLAIM	
$5,000	2.5%	$5,000	6.5%
$10,000	4.5%	$10,000	11.5%
$15,000	6.0%	$15,000	15.0%
$20,000	8.0%	$20,000	17.5%
$25,000	9.0%	$25,000	20.0%
$50,000	15.0%	$50,000	30.5%
$100,000	25.0%	$100,000	40.0%
$200,000	37.5%	$200,000	55.0%
$250,000	42.0%	$250,000	58.0%

The following Individual Deductibles are available on a Per Claim/Aggregate Basis. Premium discounts for optional deductibles will be applied, per the table below, to the rate for the applicable primary limit:

Indemnity Only Per Claim/Aggregate		Indemnity & ALAE Per Claim/Aggregate	
$5000/15,000	2.0%	$5000/15,000	5.5%
$10,000/30,000	4.0%	$10,000/30,000	10.5%
$25,000/75,000	8.5%	$25,000/75,000	19.0%
$50,000/150,000	14.0%	$50,000/150,000	29.5%
$100,000/300,000	24.0%	$100,000/300,000	43.0%
$200,000/600,000	36.0%	$200,000/600,000	53.5%
$250,000/750,000	40.0%	$250,000/750,000	56.5%

2. Group Deductibles

An optional deductible, which limits the amount the entire group will have to pay, if multiple claims are made in a policy year, is available. Under this program, the per claim deductible continues to apply separately to each insured involved in a suit. However, the aggregate deductible applies to all insureds in the group combined thereby reducing the organization's maximum potential liability in a policy year. When the organization is insured with a separate limit of coverage, the organization is counted when totaling the number of insureds below. Group deductible amounts apply to primary premium up to $1M/3M only. The applicable Deductible Discount will not change during the policy term despite changes in the number of insureds, but will be limited by any applicable maximum credit amount.

Indemnity Deductible Per Claim/Aggregate	Number of Insureds				Maximum Credit
($000)	2-19	20-40	41-60	61-100	
5/15	.020	.018	.015	.012	$10,500
10/30	.038	.035	.030	.024	21,000
25/75	.084	.079	.070	.058	52,500
50/150	.145	.139	.127	.109	105,000
100/300	.234	.228	.216	.196	120,000
200/600	.348	.346	.338	.321	420,000
250/75 0	.385	.385	.381	.368	525,000

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per Claim/Aggregate	Number of Insureds				Maximum Credit
($000)	2-19	20-40	41-60	61-100	
5/15	.029	.026	.021	.017	$12,750
10/30	.068	.063	.054	.043	25,500
25/75	.119	.112	.099	.082	63,750
50/150	.186	.179	.163	.140	127,500
100/300	.258	.252	.239	.216	255,000
200/600	.396	.394	.385	.366	510,000
250/75 0	.467	.467	.462	.446	637,500

D. Experience Rating

Experience Rating is under review. It is currently not available.

E. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free. A schedule is provided on Page 26 under M.

F. Individual Risk Rating

A risk may be individually rated by submitting a filing to the Illinois Department of Insurance, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code. The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual experience, location or dispersion of exposure, and shall apply to all risks under the same or substantially the same circumstances or conditions. We must list the standards by which variations in hazards or expense provisions are measured, in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

Before rates may be modified, the maximum scheduled rating credit/debit must be first applied. Following that, modifications of up to +/-50% may be applied, in increments no greater than +/-25% for each category. Categories include historical loss experience and class anomalies.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Underwriting Vice President.

B. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. The Reporting Period is unlimited.

C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.

D. Per Patient Rates – Emergency Room / Urgent Care

1. Rating of Emergency Room and Urgent Care Groups may, at the Company's option, be rated on a per 100 patient visit basis. A risk with fewer than 10,000 patient encounters each year will not qualify for this rating method.

2.For risks rated on a per patient basis, develop premium using the following per 100 patient visit rates. These rates are Claims made, $1,000,000/3,000,000. These rates are subject to decreased limit factors on page 26 of this Rate Manual. Use the Territory Definitions on page 20 of this Rate Manual.

Class	Terr 1	Terr 2	Terr 3 Terr 4	Terr 5	Terr 6 Terr 7 Terr 8
Emer Room	$2058	$1856	$1755	$1452	$1168
Urgent Care	$1553	$1401	$1325	$1098	$886

VII. PREMIUM COMPUTATION DETAILS

A. Classifications

1. Applicable to Standard Claims-Made Programs.

2. The following classification plan shall be used to determine the appropriate rating class for each individual insured.

PHYSICIANS & SURGEONS

CLASS 1

Allergy/Immunology
Forensic Medicine
Occupational Medicine
Otorhinolaryngology-NMRP, NS
Physical Med. & Rehab.

Public Health & Preventative Med
Other, Specialty NOC

CLASS 2

Dermatology
Endocrinology
Geriatrics
Ophthalmology-NS
Pathology
Podiatry, No Surgery
Psychiatry
Rheumatology
Other, Specialty NOC

CLASS 3

Pediatrics-NMRP
Other, Specialty NOC

CLASS 4

Diabetes
Family Practice-NMRP, NS
General Practice-NMRP, NS
General Surgery-NMRP
Hematology
Industrial Medicine
Neurosurgery-NMRP, NMajS
Nuclear Medicine
Oncology
Ophthalmic Surgery
Oral/Maxillofacial Surgery
Orthopaedics-NMRP, NS
Radiation Oncology
Thoracic Surgery-NMRP, NS
Other, Specialty NOC

CLASS 5

Cardiovascular Disease-NMRP, NS
Infectious Disease
Nephrology-NMRP
Other, Specialty NOC

CLASS 6

Gynecology-NMRP, NS
Internal Medicine-NMRP
Certified Registered Nurse Anesthetist
Other, Specialty NOC

CLASS 7

Anesthesiology
Nephrology-MRP
Podiatry, Surgery
Pulmonary Diseases
Radiology-NMRP
Other, Specialty NOC

CLASS 8

Cardiac Surgery-MRP, NMajS
Cardiovascular Disease-Spec. MRP
Gastroenterology
General Surgery-MRP, NMajS
Hand Surgery-MRP, NMajS
Internal Medicine-MRP
Neurology
Orthopaedics-MRP, NMajS

Otorhinolaryngology-MRP, NMajS
Pediatrics-MRP
Radiology-MRP
Urology-MRP, NMajS
Vascular Surgery-MRP, NMajS
Other, Specialty NOC

CLASS 9

Family Practice-MRP, NMajS
General Practice-MRP, NMajS
Other, Specialty NOC

CLASS 10

Neurosurgery-MRP, NMajS
Urological Surgery
Other, Specialty NOC

CLASS 11

Cardiovascular Disease-MRP
Colon Surgery
Emergency Medicine-NMajS, prim
Gynecology/Obstetrics-MRP, Nmaj
Otorhinolaryngology; No Elective
Plastic
Radiology-MajRP
Other, Specialty NOC

CLASS 12

Emergency Medicine-MajS
Family Practice-not primarily MajS
General Practice-NMajS, prim
Gynecological Surgery
Hand Surgery
Head/Neck Surgery

Otorhinolaryngology; Head/Neck
Other, Specialty NOC

CLASS 13

General Surgery
Certified Nurse Midwife
Other, Specialty NOC

CLASS 14

Neonatology
Otorhinolaryngology; Other Than Head/Neck

Plastic Surgery
Other, Specialty NOC

CLASS 15

Orthopaedic Surgery s/o Spine
Other, Specialty NOC

CLASS 16

Cardiac Surgery
Thoracic Surgery
Vascular Surgery
Other, Specialty NOC

CLASS 17

Obstetrical/Gynecological Surgery
Other, Specialty NOC

CLASS 18

Neurosurgery-No Intracranial Surgery
Orthopaedic Surgery wSpine
Other, Specialty NOC

CLASS 19

Neurosurgery
Other, Specialty NOC

MEDICAL PROCEDURE DEFINITIONS

NMRP: NOMINAL MINOR RISK PROCEDURE

NS: NO SURGERY

NOC: NOT OTHERWISE CLASSIFIED

NMAJS: NO MAJOR SURGERY

MRP: MINOR RISK PROCEDURES

MAJRP: MAJOR RISK PROCEDURES

NON PHYSICIAN HEALTH CARE PROVIDERS

Class X

Fellow, Intern, Optician, Resident, Social Worker

Class Y

Optometrist, Physical Therapist, X-Ray and Lab Technicians

Class Z

Nurse Practitioner – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Physician Assistant – Family Medicine, Gynecology, No Obstetrics, Emergency Medicine, Urgent Care

Class 1

Psychologist

Class 2

Certified Registered Nurse Anesthetist

Class 5

Certified Nurse Midwife – No complicated OB or surgery

B. Territory Definitions

TERRITORY 1 COUNTIES

Cook, Jackson, Madison, St. Clair and Will

TERRITORY 2 COUNTIES

Lake, Vermillion

TERRITORY 3 COUNTIES

Kane, McHenry, Winnebago

TERRITORY 4 COUNTIES

DuPage, Kankakee, Macon

TERRITORY 5 COUNTIES

Bureau, Champaign, Coles, DeKalb, Effingham, LaSalle, Ogle, Randolph

TERRITORY 6 COUNTIES

Grundy, Sangamon

TERRITORY 7 COUNTIES

Peoria

TERRITORY 8 COUNTIES

Remainder of State

C. Standard Claims Made Program Step Factors

First Year:	25%
Second Year:	50%
Third Year:	85%
Fourth Year (Mature):	100%

D. Mature Rates for Physicians and Surgeons (Claims-made):

$1,000,000 / 3,000,000

Class	Medical Specialty	Terr 1	Terr 2	Terr 3	Terr 4	Terr 5	Terr 6	Terr 7	Terr 8
1	Allergy/Immunology	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Forensic Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Occupational Medicine	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Otorhinolaryngology-NMRP, NS	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Physical Med. & Rehab.	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Public Health & Preventative Med	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
1	Other, Specialty NOC	14,479	13,183	12,535	11,239	10,591	9,295	7,351	7,999
2	Dermatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Endocrinology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Geriatrics	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Ophthalmology-NS	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Pathology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Podiatry, No Surgery	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Psychiatry	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Rheumatology	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
2	Other, Specialty NOC	19,339	17,557	16,668	14,886	13,993	12,211	9,540	10,429
3	Pediatrics-NMRP	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049
3	Other, Specialty NOC	22,579	20,473	19,422	17,316	16,261	14,155	10,998	12,049
4	Diabetes	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Family Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Practice-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	General Surgery-NMRP	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Hematology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Industrial Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Neurosurgery-NMRP, NMajS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Nuclear Medicine	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Ophthalmic Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Oral/Maxillofacial Surgery	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Orthopaedics-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Radiation Oncology	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
4	Thoracic Surgery-NMRP, NS	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289

4	Other, Specialty NOC	29,059	26,305	24,930	22,176	20,797	18,043	13,914	15,289
5	Cardiovascular Disease-NMRP, NS	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Infectious Disease	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Nephrology-NMRP	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
5	Other, Specialty NOC	30,679	27,763	26,305	23,389	21,931	19,015	14,641	16,099
6	Gynecology-NMRP, NS	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Internal Medicine-NMRP	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
6	Other, Specialty NOC	33,919	30,679	29,059	25,819	24,199	20,959	16,099	17,719
7	Anesthesiology	37,159	33,595	31,813	28,231	26,467	22,903	17,557	19,339
7	Nephrology-MRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Podiatry, Surgery	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Pulmonary Diseases	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Radiology-NMRP	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
7	Other, Specialty NOC	37,159	33,595	31,813	28,249	26,467	22,903	17,557	19,339
8	Cardiac Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Cardiovascular Disease-Spec. MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Gastroenterology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	General Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Hand Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Internal Medicine-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Neurology	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Orthopaedics-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Otorhinolaryngology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Pediatrics-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Radiology-MRP	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Urology-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Vascular Surgery-MRP, NMajS	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
8	Other, Specialty NOC	42,019	37,969	35,942	31,892	29,869	25,819	19,746	21,769
9	Family Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	General Practice-MRP, NMajS	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
9	Other, Specialty NOC	45,259	40,885	38,696	34,322	32,137	27,763	21,204	23,389
10	Neurosurgery-MRP, NMajS	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009

10	Urological Surgery	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
10	Other, Specialty NOC	48,499	43,801	41,450	36,752	34,405	29,707	22,662	25,009
11	Cardiovascular Disease-MRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Colon Surgery	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Emergency Medicine-NMajS, prim	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Gynecology/Obstetrics-MRP, Nmaj	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Otorhinolaryngology; No Elective Plastic	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Radiology-MajRP	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
11	Other, Specialty NOC	53,359	48,175	45,583	40,399	37,807	32,623	24,847	27,439
12	Emergency Medicine-MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Family Practice-not primarily MajS	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	General Practice-NMajS, prim	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Gynecological Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Hand Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Head/Neck Surgery	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Otorhinolaryngology; Head/Neck	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
12	Other, Specialty NOC	59,839	54,007	51,091	45,259	42,343	36,511	27,763	30,679
13	General Surgery	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
13	Other, Specialty NOC	88,999	80,251	75,877	67,129	62,755	54,007	40,885	45,259
14	Neonatology	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Otorhinolaryngology; Other Than Head/Neck	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Plastic Surgery	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
14	Other, Specialty NOC	92,239	83,167	78,631	69,559	65,023	55,951	42,343	46,879
15	Orthopaedic Surgery s/o Spine	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
15	Other, Specialty NOC	101,956	91,915	86,893	76,849	71,827	61,783	46,717	51,739
16	Cardiac Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Thoracic Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Vascular Surgery	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839
16	Other, Specialty NOC	118,156	106,492	100,660	88,999	83,167	71,503	54,007	59,839

17	Obstetrical/Gynecological Surgery	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
17	Other, Specialty NOC	124,636	112,324	106,168	93,856	87,703	75,391	56,923	63,079
18	Neurosurgery-No Intracranial Surgery	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Orthopaedic Surgery wSpine	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
18	Other, Specialty NOC	134,356	121,072	114,430	101,146	94,504	81,223	61,297	67,939
19	Neurosurgery	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576
19	Other, Specialty NOC	205,636	185,224	175,018	154,606	135,400	123,988	93,373	103,576

E. Mature Rates for non Physician Health Care Providers

Class X equals 10% of the Class 1 Physician/Surgeon rate.

Class Y equals 15% of the Class 1 Physician/Surgeon rate.

Class Z equals 25% of the Class 1 Physician/Surgeon rate.

Note any non-Physician Health Care Providers in Classes X, Y, or Z with exposure in the Emergency Room will require the referenced factor times the Class 4 rate.

F. Decreased Limit Factors:

Limit	All Classes
1M/3M	1.000
500/1.0	.7199

G. Extended Reporting Period Coverage Factors:

(1) The following represents the tail factors to be applied to the annual expiring discounted premium in the event a policyholder desires to obtain a Reporting Endorsement upon termination or cancellation of the policy:

Year	Factor
1st	3.30
2nd	3.15
3rd	2.40
4th	2.00

(2) The Reporting Period is unlimited.

H. Shared Limits Modification:

Not available.

I. Policy Writing Minimum Premium:

Physicians & Surgeons - $1250.

J. Policy Writing Minimum Premium:

Non-Physician Healthcare Providers - $500

K. Separate Limits for Non-Physician and Surgeon Healthcare Providers Modification:

Class X: 20% of Class 1
Class Y: 25% of Class 1
Class Z: 35% of Class 1

L. Premium Modifications

For individual physicians and surgeons:

1. Part Time Physicians & Surgeons – 30%
2. Physicians in Training – 1st Year Resident 50%; Resident 40%; Fellow 30%.
3. Locum Tenens – no premium, subject to prior underwriting approval
4. New Physicians & Surgeons – 30% for the first two years of practice
5. Physician Teaching Specialists – Non-surgical 50%; Surgical 40%.
6. Physicians Leave of Absence – full suspension of insurance and premium for up to one year, subject to underwriting approval

M. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit based on the following schedule:

(i) If claim free for 3 years but less than 5 years, a 5% credit shall be applied at the policy inception date.

(ii) If claim free for 5 years but less than 8 years, a 10% credit shall be applied at the policy inception date.

(iii) If claim free for 8 years but less than 10 years, a 15% credit shall be applied at the policy inception date.

(iv) If claim free for 10 years or more, a credit of 20% shall be applied at the policy inception date.

A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

N. Schedule Rating (not to be used in conjunction with Loss Rating)

1. Historical Loss Experience +/- 25%	The frequency or severity of claims for the insured(s) is greater/less than the expected experience for an insured(s) of the same classification/size or recognition of unusual circumstances of claims in the loss experience.
2. Cumulative Years of Patient Experience. +/- 10%	The insured(s) demonstrates a stable, longstanding practice and/or significant degree of experience in their current area of medicine.
3. Classification Anomalies. +/-_ 25%	Characteristics of a particular insured that differentiate the insured from other members of the same class, or recognition of recent developments within a classification or jurisdiction that are anticipated to impact future loss experience.
4. Claim Anomalies +/- 25%	Economic, societal or jurisdictional changes or trends that will influence the frequency or severity of claims, or the unusual circumstances of a claim(s) which understate/overstate the severity of the claim(s).
5. Management Control Procedures. +/- 10%	Specific operational activities undertaken by the insured to reduce the frequency and/or severity of claims.
6. Number /Type of Patient Exposures. +/- 10%	Size and/or demographics of the patient population which influences the frequency and/or severity of claims.
7. Organizational Size / Structure. +/- 10%	The organization's size and processes are such that economies of scale are achieved while servicing the insured.
g. Medical Standards, Quality & Claim Review. +/- 10%	Presence of (1) committees that meet on a routine basis to review medical procedures, treatments, and protocols and then assist in the integration of such into the practice, (2) Committees mat meet to assure the quality of the health care services being rendered and/or (3) Committees to provide consistent review of claims/incidents that have occurred and to develop corrective action.
9. Other Risk Management Practices and Procedures. +/- 10%	Additional activities undertaken with the specific intention of reducing the frequency or severity of claims.
10. Training, Accreditation & Credentialing. +/- 10%	The insured(s) exhibits greater/less than normal participation and support of such activities.
11. Record - Keeping Practices. +/- 10%	Degree to which insured incorporates methods to maintain quality patient records, referrals, and test results.
12. Utilization of Monitoring Equipment, Diagnostic Tests or Procedures +/- 10%	Demonstrating the willingness to expend the time and capital to incorporate the latest advances in medical treatments and equipment into the practice, or failure to meet accepted standards of care.

Maximum Modification	+ / - 25%

O. Deductible Credits

See V.C on Page 12.

P. Experience Rating

Not Available.

Q. Slot Rating for groups, subject to Underwriting

See VI.A on Page 13.

R. Mandatory Quarterly Payment Option.

For medical liability insureds whose annual premiums total $500 or more, the plan must allow the option of quarterly payments.

(v) An initial payment of no more than 40% of the estimated total premium due at policy inception;

(vi) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

(vii) No interest charges;

(viii) Installment charges or fees of no more than the lesser of 1% of the total premium or $25, whichever is less; and

(ix) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

Non-Mandatory Quarterly Payment Option.

(x) For medical liability insureds whose annual premiums are less than $500, insurers may, but are not required to, offer quarterly installment , premium payment plans.

(xi) For insureds who pay a premium for any extension of a reporting period, insurers may, but are not required to, offer quarterly installment, premium payment plans.

(xii) If an insurer offers any quarterly payments under this sub-section, (g) Non-Mandatory Quarterly Payment Options, they must be offered to all medical liability insureds.

Quarterly installment premium payment plans subject to (R) above shall be included in the initial offer of the policy, or in the first policy renewal. Thereafter, the insurer may, but need not, re-offer the payment plan, but if an insured requests the payment plan at a later date, the insurer must make it available.

MEDICUS™
INSURANCE COMPANY

Tuesday, November 20, 2007

Ms. Gayle Neuman
Illinois Division of Insurance
Property & Casualty Compliance
320 W. Washington St., 4th Floor
Springfield, IL 62767

RE: Medicus Insurance Company FEIN # 20-5623491 ✓
Individual Risk Rating – Richard Shatz, MD
FILE # IL-11207-Ind Risk

Dear Ms. Neuman:

Please accept this submission, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code, of an Individual Risk Rating proposal for the captioned physician. Richard Shatz, MD has applied for claims made professional medical liability insurance with Medicus Insurance Company.

Following is a summary of the submission provided to Medicus Insurance Company:

Insured:	Richard Shatz, MD
Effective Date:	January 6, 2008
Retroactive Date:	January 6, 2003
Limit of Liability:	$1,000,000/3,000,000
Location:	Quincy, Illinois
Territory:	8 (Rest of State)
Expiring Carrier:	PLICA
Expiring Premium:	$90,000
Claims Summary:	4 claims reported in past 13 years Incurred losses: $225,000
Licensure:	In February 1985, surrendered medical license to Board of Healing Arts in Missouri and was reinstated in October, 1985. This followed an investigation subsequent to his recreational use of cocaine in the years 1980-1982. He underwent counseling treatment for substance abuse and successfully completed treatment.

I-O
MEM
RVL
Jeh

8500 Shoal Creek Blvd., Building 3, Suite 200, Austin, TX 78757 USA
T 512.467.2800 WWW.MEDICUSINSURANCE.COM F 877.686.0558

The Medicus Insurance Company manual rate for this risk is $46,879. Based upon our general knowledge of Plastic Surgeons in Territory 8 of Illinois, we believe that this risk, which includes 4 settled claims in the past 13 years, and the history of substance abuse, is outside the norm in terms of risk characteristics, and justifies a debit of 70% to our manual rate.

In proposing the rate of $79,694, which is an increase of 70% to our manual rate, we believe this rate is not excessive, inadequate or unfairly discriminatory.

We request, therefore, approval of this rate, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code. I look forward to your reply at your earliest convenience.

Regards,

Bruce Arnold

8500 Shoal Creek Blvd., Building 3, Suite 200, Austin, TX 78757 USA
T 512.467.2800 WWW.MEDICUSINSURANCE.COM F 877.686.0558

Effective March 1, 2007

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only
	a. Date the filing is received:
	b. Analyst:
	c. Disposition:
	d. Date of disposition of the filing:
	e. Effective date of filing:
	New Business
	Renewal Business
	f. State Filing #:
	g. SERFF Filing #:
	h. Subject Codes

RECEIVED
NOV 27 2007
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

3.	Group Name	Group NAIC #
	Medicus Insurance Holdings, Inc.	

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	Medicus Insurance Company	Texas	12754	20-5623491	

5.	Company Tracking Number	IL-112107-Ind Risk

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Bruce Arnold, Medicus Insurance Company, 8500 Shoal Creek Blvd, Building 3, Suite 200, Austin, TX 78757	AVP	512-879-5103	877-686-0558	barnold@medicusins.com

7.	Signature of authorized filer	Bruce Arnold
8.	Please print name of authorized filer	Bruce Arnold

Filing information (see General Instructions for descriptions of these fields)

9.	Type of Insurance (TOI)	11.000 – Medical Malpractice Insurance			
10.	Sub-Type of Insurance (Sub-TOI)	11.000 – Physicians & Surgeons Medical Liability			
11.	State Specific Product code(s)(if applicable)[See State Specific Requirements]				
12.	Company Program Title (Marketing title)	Deductible Credits for Physicians & Surgeons			
13.	Filing Type	[ ] Rate/Loss Cost [ ] Rules [x] Rates/Rules [ ] Forms [ ] Combination Rates/Rules/Forms [ ] Withdrawal[ ] Other (give description)			
14.	Effective Date(s) Requested	New:	12/1/07	Renewal:	12/01/07
15.	Reference Filing?	[ ] Yes [x] No			

18.	**Company's Date of Filing**	12/1/07
19.	**Status of filing in domicile**	[x] Not Filed [ ] Pending [ ] Authorized [ ] Disapproved

Property & Casualty Transmittal Document—

20.	**This filing transmittal is part of Company Tracking #**	IL-112107-Ind Risk

21.	**Filing Description** [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

This rule has been added to the Medicus Rate Manual under V.F on Page 14.

A risk may be individually rated by submitting a filing to the Illinois Department of Insurance, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code. The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual experience, location or dispersion of exposure, and shall apply to all risks under the same or substantially the same circumstances or conditions. We must list the standards by which variations in hazards or expense provisions are measured, in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

22.	**Filing Fees** (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #:
Amount:

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

Effective March 1, 2007

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	**IL-112107**
2.	**This filing corresponds to form filing number** (Company tracking number of form filing, if applicable)	

☐ Rate Increase ☐ Rate Decrease ☐ Rate Neutral (0%)

3.	**Filing Method (Prior Approval, File & Use, Flex Band, etc.)**	File & Use

4a. Rate Change by Company (As Proposed)

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)
Medicus Insurance Company	New Program	New Program	New Program	New Program	New Program		

4b. Rate Change by Company (As Accepted) For State Use Only

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)

		COMPANY USE	STATE USE
5a	Overall percentage rate indication (when applicable)		
5b	Overall percentage rate impact for this filing		
5c	Effect of Rate Filing – Written premium change for this program		
5d	Effect of Rate Filing – Number of policyholders affected		

6.	Overall percentage of last rate revision	
7.	Effective Date of last rate revision	
8.	Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)	

9.	Rule # or Page # Submitted for Review	Replacement or withdrawn?	Previous state filing number, if required by state
01		[ ] New [ ] Replacement [ ] Withdrawn	

PC RRFS-1

Neuman, Gayle

From: Paula Battistelli [pbattistelli@medicusins.com]
Sent: Tuesday, August 05, 2008 1:06 PM
To: Neuman, Gayle
Subject: Fwd: Filing IL-112107-Ind Risk
Attachments: Actuarial letter 8-5-2008.pdf; ATT437111.htm

Ms. Neuman,
Attached is the actuarial memo that you requested for the above named filing.

If you could let me know where a blank form for the attached document exists on the IL DOI website, I would appreciate it.

Thank you.

Paula Battistelli
Regulatory Compliance Coordinator
Medicus Insurance Company
Direct: (512) 879-5128
Fax: (877) 686-0558
Email: pbattistelli@medicusins.com

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, (Name of officer typed or printed) Jeff Weigl, a duly authorized officer of (Name of Insurer typed or printed) Medicus Insurance Co. am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

I, Richard J Roth Jr FCAS Consulting Actuary, a duly authorized actuary of Bickerstaff, Whatley, Ryan & Burkhalter am authorized to certify on behalf of Medicus Insurance Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

Jeff Weigl CHIEF UNDERWRITING OFFICER 8/5/08.
Signature and Title of Authorized Insurance Company Officer — Date

Richard J. Roth (FCAS Consulting Actuary) 8/5/08
Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 20-5623491 Filing Number IL-112107-2nd Risk

Insurer's Address 8500 Shoal Creek, Bld 3, Ste 200

City Austin State TX Zip Code 78758

Contact Person's:
-Name and E-mail Paula Battistelli, pbattistelli@medicusins.com

-Direct Telephone and Fax Number (512) 879-5128 877-686-0558

Re: Individual Risk Rating – Richard Shatz, MD

Neuman, Gayle

From: Neuman, Gayle
Sent: Monday, July 21, 2008 2:00 PM
To: 'Bruce Arnold'
Subject: Filing IL-112107-Ind Risk

Mr. Arnold,

215 ILCS 5/155.18 states it shall be certified in this filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience. Please provide the required certification.

Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If a stat agency is used, please indicate which one?

Your immediate attention is requested.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

Neuman, Gayle

From: Bruce Arnold [barnold@medicusins.com]
Sent: Wednesday, February 13, 2008 9:08 AM
To: Neuman, Gayle
Subject: Re: Medicus Individual Risk Rating - Richard Shatz, MD - File #IL-112107-Ind Risk
Attachments: IL Rate Manual 112107; ATT135275.htm

Dear Ms. Neuman:

Please accept this response to your email below.

Attached please find an updated copy of the entire rate manual (indicating date in lower left corner) that coincides with the captioned filing. This includes the change being submitted in the filing. The change is located on page 14 under F. Individual Risk Rating. There are no other changes in this manual.

With respect to the comments in your email below, you are correct that I meant to indicate a debit rather than credit. I apologize for the error.

Second, you are correct that I did not indicate which category/categories of the scheduled credits/debits would be applied in this instance. The category of scheduled rating would be a 25% debit for historical loss experience.

Following that, we would apply debits, in accordance with individual risk rating. A 25% debit, also for historical loss experience, is then applied. The reason for the second use of historical loss experience is that the loss experience of this risk, which includes 4 claims in the past 13 years, is beyond the 25% debit contained in the schedule rating.

Finally, we are applying a 20% debit for class anomalies, due to the prior substance abuse.

The total of these debits is summarized as follows:

25% debit, Schedule rating, historical loss experience
25% debit, Individual Risk Rating, historical loss experience
20% debit, Individual Risk Rating, class anomalies

Finally, I have added a paragraph to F. Individual Risk Rating, on page 15, of the rating manual, which sets a maximum Individual Risk Rating modification of 50%, in increments of no more than 25%. You will note that our use of the Individual Risk Rating amounts to 45%, and is thus within the 50% maximum Individual Risk Rating modification in the manual. This additional paragraph is reflected in the updated copy of the entire rate manual that I referenced at the beginning of this email.

Should you have any questions, please let me know.

Regards,

Bruce Arnold

The following Group Deductibles are available for Indemnity & ALAE.

Indemnity & ALAE Deductible Per Claim/Aggregate	Number of Insureds				Maximum Credit
($000)	2-19	20-40	41-60	61-100	
5/15	.029	.026	.021	.017	$12,750
10/30	.068	.063	.054	.043	25,500
25/75	.119	.112	.099	.082	63,750
50/150	.186	.179	.163	.140	127,500
100/300	.258	.252	.239	.216	255,000
200/600	.396	.394	.385	.366	510,000
250/75 0	.467	.467	.462	.446	637,500

D. Experience Rating

Experience Rating is under review. It is currently not available.

E. Claim Free Credit Program

If no claim has been attributed to an Insured, the Insured will be eligible for a premium credit, based upon the number of years the Insured has been claim free. A schedule is provided on Page 26 under M.

F. Individual Risk Rating

A risk may be individually rated by submitting a filing to the Illinois Department of Insurance, in accordance with Section 155.18(b)(4) of the Illinois Insurance Code. The code allows us to modify classification rates to produce rates for individual risks. Modifications of classifications of risks may be based upon size, expense, management, individual experience, location or dispersion of exposure, and shall apply to all risks under the same or substantially the same circumstances or conditions. We must list the standards by which variations in hazards or expense provisions are measured, in order to determine that a specific risk is so different in hazard/expense that it warrants individual rating.

VI. MODIFIED PREMIUM COMPUTATION

A. Slot Rating

1. Coverage for group practices is available, at the Company's discretion, on a slot basis rather than on an individual physician basis. The slot endorsement will identify the individuals and practice settings that are covered. Coverage will be provided on a shared limit basis for those insureds moving through the slot or position.

2. The applicable manual rate will be determined by the classification of the slot. Policies rated as a Standard Claims Made policy will utilize the retroactive date of the slot. Extended Reporting Period Coverage may be purchased for the slot based on the applicable retroactive date, classification and limits.

3. Premium modifications for new physician, part time, moonlighting, teaching, risk management or loss free credit may not be used in conjunction with this rating rule, unless approved by the Underwriting Vice President.

B. Requirements for Waiver of Premium for Extended Reporting Period Coverage.

1. Upon termination of coverage under this policy by reason of death, the deceased's unearned premium for this coverage will be returned and Extended Reporting Period Coverage will be granted for no additional charge, subject to policy provisions.

2. Upon termination of coverage under this policy by reason of total disability from the practice of medicine or at or after age 55, permanent retirement by the insured after five consecutive claims made years with the Company, Extended Reporting Period Coverage will be granted for no additional charge subject to policy provisions.

3. The Reporting Period is unlimited.

C. Blending Rates

A blended rate may be computed when a physician discontinues, reduces or increases his specialty or classification, and now practices in a different specialty or classification. For example, if an OB/GYN discontinues obstetrics, but continues to practice gynecology, his new blended rate will be the sum of the indicated OB/GYN and GYN rates, each weighted, at inception of the change, by 75% and 25%, respectively. The second and third year weights will be modified by 25%, descending and ascending respectively, until the full GYN rate is achieved at the start of the fourth year.